CHAPTER 4: CONSOLIDATED BILLING 1

OBJECTIVE 1

CONSOLIDATED BILLING REQUIREMENTS 2
BBA Provisions Affecting Part A And Part B Billing 2
Who Is Governed By Consolidated Billing 2
Coverage For Preventive Services For Beneficiaries In A Covered Part A Stay 3
Inpatient Defined 4

COMPONENTS OF CONSOLIDATED BILLING 6
Services Billed On A Part A Swing Bed Claim (18X) To The Fiscal Intermediary 6
Bundling vs. Consolidated Billing 7
Services Exempt From Consolidated Billing 7
Bundling Of Charges 10
Swing Bed Beneficiaries Receiving A Service Subject To Consolidated Billing 10

SPECIAL CIRCUMSTANCES REQUIRING APPLICATION OF CONSOLIDATED BILLING PRINCIPLES 11
Leave Of Absence (LOA) 11
Services And Treatments Provided “Under Arrangement” 12
Billing And Payment Of 'Arranged' Or 'Bundled' Services 13
Enteral And Parenteral Nutrition 13

SERVICES OUTSIDE THE SCOPE OF SNF AND SWING BED CARE 14
Emergency Room Services 14
Use Of The Operating Room 14
Services Furnished “Incident To” A Professional Service 15
Dialysis Services For Part A Beneficiaries 16
Home Dialysis Beneficiaries 16
Lab And X-ray Services 17
Orthotics And Prosthetics 17
Drugs And Biologicals 18

CONSOLIDATED BILLING SPECIAL RULES FOR AMBULANCE TRANSPORT 19

SWING BED FACILITY'S RESPONSIBILITY UNDER CONSOLIDATED BILLING 20
Non-Billing Responsibilities 20
Other Responsibilities 20

BILLING RESPONSIBILITIES ON PART A CLAIMS 21
Billing Responsibilities On Part B Claims Processed By Fiscal Intermediaries 21

PAYMENT UNDER CONSOLIDATED BILLING 22
Financial Issues Regarding Payment For Part A Stays 22
Financial Issues Regarding Payment For Part B Stays 23
Billing When Part A No Longer Applies 23

CHAPTER 4: CONSOLIDATED BILLING

OBJECTIVE

Participants will learn the basic premises of the Consolidated Billing requirements and how they apply to swing bed providers under the PPS. This chapter also highlights the differences between traditional bundling and Consolidated Billing.

CONSOLIDATED BILLING REQUIREMENTS

BBA Provisions Affecting Part A And Part B Billing

Section 4432 (b) of the Balanced Budget Act (BBA) of 1997 contains the requirement that SNFs must submit **all** Medicare claims for **all** the services provided to their residents with the exception of statutory exclusions beginning July 1, 1998.

Since that time, additional exclusions have been established under CMS's administrative authority and under the Balanced Budget Refinement Act (BBRA). The specific Part A–covered services that are excluded from the SNF PPS rate are discussed later in this chapter.

Who Is Governed By Consolidated Billing

Consolidated Billing Applies to Medicare Fee-For-Service Beneficiaries

Consolidated Billing requirements govern all services provided to Medicare fee-for-service beneficiaries residing in a participating SNF during a covered Part A stay.

- Consolidated Billing began for the Part A resident with the SNF's first cost report year on or after 07/01/98

- **Swing bed facilities** are affected by these regulations beginning with their next hospital cost report year starting on or after **July 1, 2002**

Coverage For Preventive Services For Beneficiaries In A Covered Part A Stay

Preventive services are not included in the SNF PPS per diem rate for Part A residents of a swing bed. They may be separately billed under the swing bed facility's acute care hospital provider number.

- Preventive services are subject to hospital bundling provisions

- Preventive care services are separately billed under the **hospital provider number using type of bill 12X** for the Part A swing bed beneficiary

Inpatient Defined

For the purposes of Consolidated Billing, a Medicare beneficiary who resides in a swing bed is considered to be an **inpatient for the SNF benefit** until such time the resident's status changes by one of the following actions:

- Discharged to home, self care
  (status **01** in FL 22)

- Discharged/transferred to another short term general hospital for inpatient care
  (status **02** in FL 22)

- Discharged/transferred to SNF
  (status **03** in FL 22)
  (status **61** to another swing bed hospital)

- Discharged/transferred to non-certified SNF, ICF or NF
  (status **04** in FL 22)

- Discharged/transferred to another type of institution (including distinct parts)
  (status **05** in FL 22)

- Discharged/transferred to home under HHA care
  (status **06** in FL 22)

- Left against medical advice or discontinued care (status **07** in FL 22)

- Expired (or did not recover-Christian Science patient)
  (status 20 in FL 22)

- Discharged to hospice - home
  (status **50** in FL 22)

- Discharged to hospice - medical facility
  (status **51** in FL 22)

The hospital bundling requirements applicable to swing beds are **similar** to the SNF Consolidated Billing provisions mandated by the BBA. Charges for **most** covered Part A services must be charged back to the swing bed if the beneficiary is covered under Medicare Part A **and** the swing bed is receiving swing bed PPS payment for that day.

Leave of Absence Days
- Services rendered by an outside provider on LOA days do **not** have to be bundled back to the swing bed

- Services rendered by an outside provider on the day of beneficiary's discharge or on Leave Of Absence (LOA) days do **not** have to be bundled back to the swing bed for payment because the resident is **not considered to be an "inpatient" of the swing bed on those days and no Part A reimbursement is made by Medicare**

- Services rendered to a beneficiary in the swing bed on any day in which they have a LOA are coded to the swing bed claim if they are rendered before the beneficiary leaves the swing bed facility

COMPONENTS OF CONSOLIDATED BILLING

Services Billed On A Part A Swing Bed Claim (18X) To The Fiscal Intermediary

Requirements for Part A Claims

- All services allowed under Part A stay per section 230 of the SNF Manual (HCFA Pub. 12) must be reported on a UB-92 using a line item ancillary revenue code and total charges for that service

- Services required to be included on the Part A claim are those rendered **within the facility** (either directly or under arrangement) and **those rendered "off-site"** (with the exception of those services excluded by BBA, BBRA and by CMS administrative action)

- HIPPS code from SB-MDS grouper and accommodation charges

- See addendum to this manual for exclusions

Bundling vs. Consolidated Billing

Bundling and Consolidated Billing
- Swing bed facilities are affected by both

Like hospitals, swing bed facilities are subject to hospital bundling requirements; but as providers of SNF services, they are also affected by the Consolidated Billing policies.

- Under the hospital bundling regulations, only limited services are separately billed to Medicare Part B (including emergency room, operating room)

The statute excludes several services from Consolidated Billing that it does not exclude from hospital bundling. However, since the Part A SNF PPS payment does not include reimbursement for any of the statutorily excluded services, **the swing bed hospital can separately bill the Medicare Part B benefit for any of these *excluded* services.**

Services Exempt From Consolidated Billing

CMS has provided a list of those services not normally within the SNF purview to provide and therefore, **not** bound by Consolidated Billing rules. Hospital bundling provisions do **not** apply to these services, which must actually be billed as inpatient Part B services.

Excluded Services:

These Medicare covered services may be separately billed and reimbursed when provided to beneficiaries in a Part A stay.

Excluded Services Per Interim Final Rule

Exclusions Originally Listed In the *Interim Final Rule (IFR)*

- Physicians (**professional component** of physician services)
- Physician assistants working under a physician's supervision
- Nurse practitioners and clinical nurse specialists working in collaboration with a physician
- Certified nurse-midwives
- Qualified psychologists
- Certified registered nurse anesthetists
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies
- Erythropoietin (EPO) for certain dialysis patients
- Hospice care related to a beneficiary's terminal condition
- An ambulance trip that transports a beneficiary to the SNF for the initial admission or from the SNF following a final discharge
- **For 1998 only** - transportation costs of EKG equipment for electrocardiogram test services (HCPC R7006) rendered during 1998

Consolidated Billing Administrative Exclusions Effective July 1, 1998 As Specified In The Federal Register/Vol. 63 No. 91, And In PM A-98-37 (November 1, 1998) And Reissued As PM A-00-01 in January 2000

Additional Exclusions

These services must be provided in a hospital or critical access hospital (CAH):

- Cardiac catherization
- CT scans
- MRI
- Ambulatory surgery involving the use of an operating room
- Emergency room services billed to the intermediary under revenue code 045X

Additional Exclusions In The CMS Transmittal A-98-37, Effective November 1, 1998

- Radiation therapy
- Angiography
- Lympathatic and venous procedure

Additional Exclusions Per The Balanced Budget Refinement Act (BBRA) Of 1999 Effective 04/01/00

- Certain chemotherapy items
- Certain chemotherapy administration services
- Certain radioisotope services
- Certain customized prosthetic devices
- Certain ambulance transport for renal dialysis services

Bundling Of Charges

The *Interim Final Rule* and *Final Rule for SNF PPS* both refer to the "bundling of charges". This means that under Consolidated Billing provisions; the costs for rendering services (other than those excluded) to a SNF Part A resident must be charged back to the SNF for payment. These Consolidated Billing provisions are often referred to as the "bundling of charges".

For those services that are subject to Consolidated Billing or hospital bundling, separate claims may **not** be submitted to Medicare Part B Carrier by an outside supplier.

Swing Bed Beneficiaries Receiving A Service Subject To Consolidated Billing

- Code claim to the **hospital** provider number under type of bill **13X**

SPECIAL CIRCUMSTANCES REQUIRING APPLICATION OF CONSOLIDATED BILLING PRINCIPLES

Leave Of Absence (LOA)

Medicare beneficiaries absent from the swing bed at midnight 'census taking' time must be considered to be on a leave of absence.

A Resident On A LOA At Midnight Cannot Use A Part A Benefit Day.

Leave of Absence
- Benefit days are not applied
- Part A reimbursement is not made
- Consolidated Billing does not apply

- Benefit days are not applied, nor is Part A reimbursement made, if the beneficiary is absent at midnight

- Consolidated Billing rules do **not** apply if the swing bed is not receiving Part A PPS reimbursement except for services received by the beneficiary before they left the swing bed on a LOA

A swing bed Part A resident who is absent at midnight is **no longer considered an "inpatient" for Consolidated Billing purposes**.

- During medical absences beyond midnight, the charges for services rendered **may be billed directly** to Medicare **by the entity performing the service**, as long as that provider meets statute requirements

Services And Treatments Provided "Under Arrangement"

Consolidated Billing requires that services provided by individuals or companies other than the employees of the swing bed must be billed to the FI on the HCFA 1450 for Medicare beneficiaries covered under Part A. The swing bed must do the billing.

- These outside providers must look to the swing bed for reimbursement, **not Medicare Part B**

Items Provided By Outside Suppliers/Contracted Staff To SNF Part A Residents

Changes to Billing for "Under Arrangement" Services
- DMERC billing
- Carrier billing

- orthotics/prosthetics
- ostomy/colostomy supplies
- sterile dressings/surgical dressings and supplies
- enteral/parenteral nutrition and supplies
- independent laboratories
- portable x-ray companies
- therapy professionals rendering PT, OT, SP

Services Provided To SNF Residents Outside The Swing Bed Facility

In addition to inpatient services rendered to a swing bed patient, **certain other services** provided to a Medicare beneficiary **outside** of the facility must be charged back to the swing bed by the outside provider.

Billing for Services Rendered out of the SNF

- All services, **unless excluded by statute,** must be bundled back to the swing bed for payment and for reporting to the FI on a HCFA 1450 (UB-92)

- Ambulance services for medically necessary transport (as defined by Carrier criteria) of SNF **inpatients** to outside services unless specifically excluded.
    - *See the special rules on page 19 regarding ambulance transport*

Billing And Payment Of 'Arranged' Or 'Bundled' Services

- The swing bed facility must include all of the bundled services on its bill to the FI

- Any outside providers must look to the swing bed hospital (not the FI) for payment

Swing bed facilities are free to choose vendors and providers for contractual agreements as long as those agreements do not violate the existing anti-kickback statutes.

Enteral And Parenteral Nutrition

Medicare Part A:

- Parenteral nutrition is considered a drug and is reported under revenue code 0260 (IV drugs), and supplies to administer the nutrition are reported under revenue code 0270 (medical/surgical supplies) or revenue code 0264 (IV therapy supplies)

- Enteral nutrition is considered "**routine**" under Medicare Part A and is **not separately billable to the FI or to the DMERC** by the swing bed

SERVICES OUTSIDE THE SCOPE OF SNF AND SWING BED CARE

The July 30, 1999 Final Rule (64 FR 41675-76) makes the following clarification regarding the exclusion of certain high-intensity outpatient hospital services from Consolidated Billing, based on their being beyond the scope of the SNF comprehensive care plan.

An outpatient hospital service is not excluded from Consolidated Billing merely because it does not appear in the **particular** care plan of the individual beneficiary receiving the service. In fact, Consolidated Billing excludes only those types of outpatient hospital services that CMS specifically identifies as being **generally** beyond the scope of SNF care plans**.**

Emergency Room Services

Services in the Emergency Room
- Exempt from Consolidated Billing if treatment is for "life or death" or involves "serious impairment of health"

Emergency room services are **exempt** from Consolidated Billing provisions **if**:

- Treatment is for a “life or death” situation or one involving “serious impairment of health”

Any unrelated routine services provided to the patient while in the emergency room must be charged back to the swing bed provider.

Use Of The Operating Room

Ambulatory surgery services must be rendered in an operating room in order to be exempt from Consolidated Billing provisions.

- With respect to **PEG tube procedures**; CMS considers the use of the GI suite or endoscopy suite as equivalent to the use of the operating room for the purpose of this exclusion

Services Furnished "Incident To" A Professional Service

The professional component of physicians and other professionals (see BBA list of those medical personnel excluded from bundling) are billed directly to the Part B Carrier.

Services "Incident to" a Professional Service

- Professional components are billed to the Part B Carrier
- Services "incident to" the professional service are billed on the Part A claim to the FI

- Services "incident to" the professional service must be billed on the swing bed Part A claim to the FI

  Examples of services "incident to" are surgical dressings, when ordered by the physician

- The technical component of a visit with a professional is **not** exempt from Consolidated Billing and must be bundled back to the swing bed

- The physician or other professional must then look to the SNF (not the FI) for payment of the technical component

Dialysis Services For Part A Beneficiaries

Dialysis in a SNF
- May be excluded or not excluded

Dialysis services are **excluded** from the Consolidated Billing provision **if**:

- Services are rendered to the beneficiary **on the site** of a Medicare certified ESRD facility or a hospital certified by Medicare to render outpatient dialysis

- Supplies and equipment are provided to a beneficiary in a SNF who has been **trained to** perform self-dialysis (See discussion of home dialysis below)

Dialysis services **are *not* excluded** from the Consolidated Billing provision if:

- Services are provided to the beneficiary **at the swing bed hospital** by staff from an ESRD facility or hospital under arrangement

    - Services provided **on the site of the swing bed** are included in the daily swing bed PPS rate

    - The swing bed must pay the ESRD or hospital **and** report these charges on the swing bed claim to the FI

Home Dialysis Beneficiaries

- The supplies and equipment for home dialysis beneficiaries residing in a swing bed are excluded from Consolidated Billing provisions

    - Equipment and supplies may not be shared with other residents

    - Nursing staff assistance to perform home dialysis in the swing bed may not be billed separately to Medicare – this service is considered "**routine**"

Lab And X-ray Services

Lab and X-ray charges should be billed to the swing bed by the entity performing the service for Part A beneficiaries. (In swing bed hospitals, the labs are usually part of the hospital)

Billing of Ancillaries

- If the facility has its own lab and radiology units, the services are included on the Part A claim , and are billed directly to the FI by the swing bed hospital

- If services are performed by portable X-ray companies, independent labs, or other hospitals, the claims are sent by the respective provider to the swing bed for payment

    - The swing bed **must** report these services on the Part A claim

Orthotics And Prosthetics

Orthotics and prosthetics supplies and equipment are governed by the Consolidated Billing provisions of BBA.

- Supplies and equipment received by the beneficiary during a Part A stay are the financial responsibility of the swing bed facility

- The supplier must look to the swing bed facility for payment, not the DMERC

- The BBRA of 1999 excluded certain customized prosthetic devices, identified by HCPCS code, from Consolidated Billing

Drugs And Biologicals

Drugs and biologicals are a covered service under **Part A** in a swing bed and are **included** in the PPS payment.

- Drugs obtained from an outside source are the financial responsibility of the swing bed

- The beneficiary's supplemental insurance (prescription policy) should **not** be used when obtaining prescriptions until his/her Part A stay ends

CONSOLIDATED BILLING SPECIAL RULES FOR AMBULANCE TRANSPORT

Ambulance Rules

Medicare payment can be made for medically necessary ambulance services. Consolidated Billing provisions apply to swing bed Part A beneficiaries.

Swing bed facilities are **not** responsible for payment for Part A residents if an ambulance transports the beneficiary for:

- Initial admission to a SNF if the beneficiary is transferring in from home or from another SNF
- Final discharge to home
- Hospital inpatient admission (not an issue for swing bed patients unless the transfer is to another hospital)
- To and from a dialysis facility for treatment
- Transport to or from services excluded from the consolidated billing provisions by administrative action. (See page 9)

Swing bed facilities are responsible to make direct payment to an ambulance company whenever the swing bed resident is transported by ambulance for:

- Outpatient hospital services except for services that have been excluded by administrative action when the beneficiary is transported to another hospital (other than the swing bed hospital)
- Transfers to a SNF

NOTE: Medicare does **not** cover transportation via ambulette, wheelchair van, taxi, or public transportation.

SWING BED FACILITY'S RESPONSIBILITY UNDER CONSOLIDATED BILLING

Non-Billing Responsibilities

In addition to preparing accurate, complete claims on a HCFA 1450 for processing by the FI, swing bed facilities are required to monitor and regulate all patient care (including those services rendered under arrangement).

Swing Bed Facilities **Must** Notify and Pay Any Outside Provider If They Are Treating a Part A Beneficiary
- Unless the service provided is an excluded service

The swing bed facilities **must** notify any outside provider if they are treating a Part A beneficiary in order for that provider to correctly direct the charges back to the swing bed facility for payment **(unless they are providing an excluded service).**

The swing bed facility **must pay** for any service provided to a Part A beneficiary by an outside supplier **unless** that service is excluded from Consolidated Billing.

Other Responsibilities

Non-Billing Responsibilities

- Medical necessity of services
- Contracts with outside suppliers
- Certificates of Medical Necessity (CMN) from suppliers
- Payment to contractors for services rendered “under arrangement”

BILLING RESPONSIBILITIES ON PART A CLAIMS

Coding Part A Claims Per Consolidated Billing Requirements

- In addition to the HIPPS code for the RUG-III group in which the resident was classified, Part A claims (18X bill type) **must** contain a line item listing (by revenue code) of **all services** rendered to the swing bed **inpatient** during the dates of service on the claim

- Adjustments must be sent to the FI if the swing bed facility receives bills from outside suppliers or other providers of service whose charges should have been applied to an original SNF claim

    - Swing bed facilities are responsible for billing the claim, and making payment to those contractors who have provided services to their Part A beneficiaries

Assignment
- Swing bed facilities **may not** "assign" legal responsibility **or** the right to receive Medicare payment

Swing bed facilities **may** contract with billing agencies for preparation and submission of claims to the FI, **but may not** “assign” to any other entity the legal responsibility for the claim or the right to receive Medicare payment.

Billing Responsibilities On Part B Claims Processed By Fiscal Intermediaries

HCPCS Coding
- Required on Part B Claims

There is no Part B benefit in a swing bed, therefore, following the end of Part A services, the beneficiary is eligible only for hospital ancillary services under Part B.

- Consolidated billing **does not** apply to Part B services **with the exception** of therapy services

PAYMENT UNDER CONSOLIDATED BILLING

Payment for Ancillaries on a Part A Claim Are Factored into the SNF PPS Reimbursement

Payment for ancillary services that are billed on a Part A claim are **factored into** the RUG-III rate for each category.

- Payment includes all reimbursement for services: routine/capital/ancillary
  - **Except** for costs associated with operating approved educational activities
- Total payment will be the full Federal PPS rate

Payment for Ancillaries on a Hospital Inpatient Part B Claim
- Fee Schedule
- Percentage of Charges

Part B claims are billed as inpatient hospital Part B services under the **hospital** provider number. The ancillary services are paid according to the fee schedule for those services in which CMS has an established fee schedule in place and HCPCS will be required.

- All others will be paid based on the existing methodology until a fee schedule is developed for that service

Financial Issues Regarding Payment For Part A Stays

Based on their participating agreements, swing bed facilities **may not charge the beneficiary the difference** between the Medicare payment and the charges on the claim.

- Beneficiaries are financially responsible for co-insurance amounts and services non-covered by Medicare for which a written notice of non-coverage has been issued

Swing bed facilities will be in violation of their provider agreements if they discriminate against the Medicare beneficiary in their admission practices or in delivery of medically necessary services.

Financial Issues Regarding Payment For Part B Stays

Consolidated Billing **does not apply** to Part B services **except** for therapy.

There is **no** Part B Benefit in a swing bed.

Billing When Part A No Longer Applies

Per *Hospital Manual (HCFA Pub. 10)* the following services are billable on a Part B claim (12X).

There is no swing bed Part B benefit. Services covered by Medicare Part B for swing bed residents (not covered by Part A) must be billed under the **hospital** provider number, **not** the swing bed provider number, to the Fiscal Intermediary

- Per Section 228 of the of the Hospital Manual (HCFA Pub. 10) the following services are billable on a Part B claim (12X)

Services Billed on Part B (12X) Claims

  - Diagnostic laboratory tests
  - Diagnostic X-rays, radiological services, radium and radioactive isotope therapy
  - Surgical dressings, splints, casts and other devices used for the reduction of fractures and dislocations
  - Leg, arm, back and neck braces, trusses, and artificial legs, arms and eyes (including adjustment, repairs and replacements)
  - Vaccinations or inoculations specifically for flu, PPV and hepatitis B
  - Approved oral cancer and anti-emetic drugs
  - Hemophilia clotting factor
  - Ambulance
  - Physical, occupational and speech therapy
  - Inpatient dialysis services (billed under revenue code 0801)